III

I

INDEX

	Page
Opinions below	1
Jurisdiction	1
Questions presented	2
Statement	2
Argument	7
Conclusion	14

CITATIONS

Cases:

Bavisotto v. *United States*, 18 F. Supp. 355 — 11

Jones v. *United States*, 106 F. (2d) 888 — 10

Ritter v. *United States*, 28 F. (2d) 265 — 11

United States v. *Depew*, 100 F. (2d) 725 — 11

United States v. *Riggins*, 65 F. (2d) 750 — 11

Statutes:

Act of June 7, 1924, c. 320, 43 Stat. 615–628, Titles II, III, IV — 8

Act of June 7, 1924, 43 Stat. 615–628, as amended by the Act of July 3, 1930:

Sec. 1 (c. 863, 46 Stat. 1016; 38 U. S. C. Sec. 11) — 8, 9

Sec. 5 (c. 849, 46 Stat. 991; c. 863, 46 Stat. 1016, 38 U. S. C. Sec. 426) — 8, 9

Miscellaneous:

Federal Rules of Civil Procedure for the District Courts of the United States, Rule 52 (a) — 12

430649—41

In the Supreme Court of the United States

OCTOBER TERM, 1941

No. 729

LINA H. HALVERSON, PETITIONER

v.

UNITED STATES OF AMERICA

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES CIRCUIT COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF FOR THE UNITED STATES IN OPPOSITION

OPINIONS BELOW

The District Court of the United States for the Northern District of Illinois rendered no opinion. Its findings of facts and conclusions of law appear at R. 80–81. The opinion of the Circuit Court of Appeals for the Seventh Circuit (R. 96–101) is reported in 121 F. (2d) 420.

JURISDICTION

The judgment of the Circuit Court of Appeals was entered on June 25, 1941 (R. 101), and a petition for rehearing was denied on August 4, 1941 (R. 102). The petition for a writ of cer-

tiorari was filed November 4, 1941. The jurisdiction of this Court is invoked under Section 240 (a) of the Judicial Code, as amended by the Act of February 13, 1925.

QUESTIONS PRESENTED

In a suit on an insurance policy the Government defended on the ground of fraud in its procurement. Petitioner alleged that the Government was estopped to assert the fraud.

The questions presented are:

1. Whether there is any basis for estoppel.

2. Whether the findings of the District Court that the insurance policy was obtained by fraud are clearly erroneous.

STATEMENT

Petitioner seeks to recover the proceeds of a $10,000 policy of United States Government life insurance issued to Harry Melvin Halverson on his application dated March 11, 1931 (R. 2–5). In its answer in the District Court, the Government asserted the single defense that the policy was obtained by fraud in that, in the application for it, the insured answered falsely and fraudulently certain questions, material to the risk, regarding his health (R. 9–11). Petitioner denied that the insured had answered either falsely or fraudulently, and alleged that, in any event, the Government was estopped to assert the defense of fraud because it had accepted premiums after

February 1933, when the Compensation Division of the Veterans' Administration received true information regarding the matters alleged to have been misrepresented by the insured (R. 13–14).

By consent of the parties, the case was submitted to the court for trial, without a jury (R. 16). Uncontradicted evidence tended to show the following:

In his application for the policy, executed on March 11, 1931 (R. 47–50), the insured represented as true, to the best of his knowledge and belief, that he had never been treated for any disease of the kidneys or bladder, and had not consulted a physician in regard to his health since the date of his discharge from the military service in 1919 (R. 50).

At least as early as April 1930, the insured had observed blood in his urine (R. 27, 30, 65), and had reported this fact to Dr. Bowe, who advised him to have a cystoscopic examination (R. 27, 65). Insured sought and obtained such an examination from Dr. Broman in September 1930. He complained of blood in his urine and the examination revealed that a wart-like growth inside his bladder was the source of it (R. 33–34, 65–66). The growth appeared not to be malignant at that time and, in the opinion of Dr. Broman, the condition could have been cured by cauterization. His advice to the insured to return for such treatment was not followed (R. 34, 66).

Upon a medical examination in June 1931, sought by the insured, blood was again found in his urine and hospital care was advised (R. 46). His condition was diagnosed as cancer in December 1932, and remained essentially stationary for a number of years, but finally became very malignant, causing his death on May 28, 1937 (R. 30–31, 60–64).

The insured discussed his condition with Dr. Bowe as early as 1920 but the petitioner, in her testimony, characterized that discussion, as well as the one referred to above when, in 1930, the same doctor advised a cystoscopic examination, as mere friendly conversations and not consultations in regard to his health (R. 65). Dr. Bowe testified that he made an examination of the insured on each of those occasions, which included at least the taking of his blood pressure and a urinalysis; that in 1920 the insured complained of having inflammation and pain of the bladder; that in 1930 he stated that he had observed blood in his urine; that in 1920 the diagnosis was guarded cystitis, acute inflammation of the bladder; and that although no diagnosis was made in 1930, a cystoscopic examination was advised because of a suspicion that there was some form of bleeding from the bladder (R. 27).

The petitioner testified, in effect, that after the cystoscopic examination in September 1930, the insured felt that his condition was not serious,

and no longer manifested uneasiness about it. Without reference to the medical examination of the insured in June 1931, which disclosed the presence of blood in his urine, she expressed the view that he forgot about his condition entirely from September 1930 to December 1932 (R. 66).

In support of his claims for compensation filed in the Veterans' Administration in February 1933 and April 1936, the insured stated that he was suffering from kidney and bladder trouble which began about February 1920, and that he had been treated for it by Dr. Bowe in 1920 and 1930, and by Dr. Broman in 1930 (R. 53–56). He made a similar recitation in an application for disability benefits under his insurance policy filed in the Veterans' Administration about May 13, 1937 (R. 57). In a letter dated July 6, 1937, the Director of Insurance of the Veterans' Administration advised the petitioner that the case had been reviewed and a determination made that the insured had made fraudulent statements in his application for insurance and that, accordingly, the proceeds of the policy could not be paid (R. 74–75).

Richard B. Posey, technical adviser on insurance in the Veterans' Administration, testified in effect, that since about 1920 insurance and compensation have been administered by separate divisions within the Veterans' Administration under such circumstances that information known

to the officials of one division, or contained in its files, would not in ordinary course reach the files or officials of the other division unless specifically requested. The question on the compensation application, "Did you ever apply for War Risk Insurance?" (R. 54), had its origin, this witness testified, prior to 1920, when insurance and compensation were handled by one division, and it had been retained because it had proved useful as a means of identifying the veteran on whose behalf claim was asserted (R. 43–44).

The court's findings of fact included findings that, in his application for the policy, the insured falsely and fraudulently, with the intent to mislead and defraud the Government, represented that he had never been treated for any disease of the kidneys or bladder, and that he had not consulted a physician in regard to his health since his discharge ~~disability~~ from the military service in 1919; that the misrepresentations and concealments were material to the issuance of the policy (R. 80). The court concluded that the policy was void because it had been procured fraudulently, and that the Government was not estopped to assert the fraud (R. 81).

From the judgment for the Government, entered in accordance with the court's findings of fact and conclusions of law (R. 81–82), petitioner appealed to the Circuit Court of Appeals for the Seventh Circuit. That court affirmed the

judgment of the District Court, pointing out in its opinion that the evidence was sufficient to warrant the findings of the District Court, and holding that the Government was not estopped to assert the defense of fraud (R. 96–101).

With respect to estoppel, the Circuit Court of Appeals held, in effect, that knowledge of facts revealed to the Compensation Division of the Veterans' Administration concerning the insured's treatment and consultation with doctors cannot be imputed to the Insurance Division, and that there was no duty on the part of the Insurance Division to examine the records, other than those of that Division, to ascertain whether the representations made by the insured, in his application for insurance, were true or false (R. 100).[1]

ARGUMENT

I

(a) The contentions advanced by petitioner concede, in effect, both that estoppel would not flow from the continued receipt of premiums in the absence of knowledge of the truth by the Administrator of Veterans' Affairs, and that neither

[1] It was, consequently, unnecessary for the court to determine whether the facts were otherwise sufficient to support the alleged estoppel or whether, if all the elements of estoppel existed, the Government would be bound by neglect of duty of its agents. These questions are reserved for argument if certiorari should be granted.

the Administrator personally, nor any subordinate official authorized to act for him in respect to insurance matters, had such knowledge earlier than May 13, 1937, when the insured's application for insurance benefits was received (R. 57–58), i. e., 15 days prior to his death (Cf. Pet. 17–19).

But petitioner contends that under Section 5 of the World War Veterans Act, as amended July 3, 1930 (38 U. S. C., Sec. 426), the Administrator of Veterans' Affairs is chargeable with knowledge with respect to insurance of facts which were made known only to the Compensation Division with respect to compensation. She, consequently, asserts that the Veterans' Administration had knowledge of the alleged fraud at least as early as February 1933, when the insured filed his application for compensation (Pet. 19). We submit, however, that petitioner's contention is clearly untenable.

The Veterans' Administration was created by consolidation of a number of agencies previously administering laws relating to relief and other benefits to former members of the military and naval service, including the Bureau of Pensions, the National Home for Disabled Volunteer Soldiers, and the United States Veterans' Bureau (c. 863, sec. 1; 46 Stat. 1016). Under the World War Veterans' Act of June 7, 1924, the Veterans' Bureau was charged with the responsibility of ad-

ministering the laws pertaining to compensation and treatment of veterans (Title II), the laws relating to veterans' insurance (Title III), and the laws providing for vocational rehabilitation (Title IV) (c. 320, 43 Stat. 615–628).

The statute authorizing creation of the Veterans' Administration provided in part (Sec. 1, Act of July 3, 1930, c. 863, 46 Stat. 1016, 38 U. S. C. Sec. 11):

> (b) Under the direction of the President the Administrator of Veterans' Affairs shall have the power, by order or regulation, to consolidate, eliminate, or redistribute the functions of the bureaus, agencies, offices, or activities in the Veterans' Administration and to create new ones therein, and, by rules and regulations not inconsistent with law, shall fix the functions thereof and the duties and powers of their respective executive heads.

Section 5 of the World War Veterans' Act, as amended July 3, 1930 (38 U. S. C. Sec. 426), upon a portion of which petitioner relies (Pet. 18), provides that the Administrator shall administer, execute, and enforce the provisions of the Act, make rules and regulations to carry out the purposes of it, decide all questions arising under it, and, further, that:

> All officers and employees of the Veterans' Administration shall perform such duties as may be assigned them by the Administrator. All official acts performed

> by such officers or employees specially designated therefor by the Administrator shall have the same force and effect as though performed by the Administrator in person. * * * The Administrator shall adopt reasonable and proper rules to govern the procedure of the divisions and to regulate and provide for the nature and extent of the proofs and evidence and the method of taking and furnishing the same in order to establish the right to benefits of compensation, insurance, vocational training, or maintenance and support allowance provided for in this Act, the forms of application of those claiming to be entitled to such benefits, the methods of making investigations and medical examinations, and the manner and form of adjudications and awards: * * *.

Since this statute prevents the act of any subordinate official within the Veterans' Administration being regarded as the act of the Administrator, unless such act be taken in the course of the performance of duties assigned to him by the Administrator, the acts of the officials designated to administer the compensation provisions of the statute are plainly not the acts of the Administrator regarding insurance. Consequently, the Circuit Court of Appeals properly held that the estoppel contention urged by the petitioner was without merit.

The same result was reached upon identical facts in *Jones* v. *United States,* 106 F. (2d) 888,

890–891 (C. C. A. 5), and the same conclusion was reached in *United States* v. *Riggins,* 65 F. (2d) 750 (C. C. A. 9), and *United States* v. *Depew,* 100 F. (2d) 725 (C. C. A. 10), upon facts differing only in that the truth was contained in the files of some other department of the Government instead of some other division of the Veterans' Administration. See also *Ritter* v. *United States,* 28 F. (2d) 265, 267 (C. C. A. 3), cited by the petitioner (Pet. 18), holding that the acts of an official of the Bureau of Internal Revenue, not connected with performance of the duties assigned to him by the Commissioner, were not to be regarded as the acts of the Commissioner.

It follows, therefore, that knowledge of the fraud was not imputable to the proper officials of the Veterans' Administration until the insured filed his application for insurance benefits on May 13, 1937. There is, accordingly, no basis for petitioner's assumption that the Administration collected some $800 in premiums subsequent to its knowledge of the fraud (Pet. 21–22).[2]

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[2] There is not here involved, of course, any question as to the return of premiums retained by the Administration after it had acquired knowledge of the fraud. Petitioner did not pray in this suit for the return of the premiums but merely sought recovery of the proceeds of the insurance (R. 2–4), and the Government was not required to tender the return of the premiums as a prerequisite to the assertion of its defense of fraud. See *Bavisotto* v. *United States,* 18 F. Supp. 355 (W. D. N. Y.), citing numerous authorities.

(b) In her reasons for the allowance of the writ (Pet. 10–13), petitioner asserts that the Circuit Court of Appeals decided that the Government is not bound by the same rules as private insurance companies with respect to insurance of the character here involved. It is obvious, however, from the opinion of the Circuit Court of Appeals, that no such question was decided, and we submit that the proper disposition of the case does not require any such decision.

II

Petitioner's attack upon the findings of the District Court consists solely of the contention that the court erred in finding that the insured, prior to his insurance application, had consulted a physician in regard to his health, and had been treated for disease of the kidneys or bladder. She takes the position (Pet. 10) that a casual discussion with a physician on two occasions ten years apart, and the examination by another physician, do not constitute consultation and treatment. She relies upon that portion of the evidence, and those inferences drawn from it, that are most favorable to her (Pet. 4–5, 23).

But the issues of fact were determined, of course, by the District Court as a trier of the facts, and its findings will be set aside only if they are clearly erroneous. Rule 52 (a) of the Federal Rules of Civil Procedure for the District Courts of the United States.

There is ample evidence, which the District Court was entitled to believe and accept as true, tending to show that insured's condition prior to his application for insurance was not of a trivial or temporary nature of the character referred to in the decisions cited by petitioner (Pet. 23–24); that the insured was well aware that he had a disease of the bladder, manifested by blood in his urine as early as 1929; that on two occasions, and at his request, Dr. Bowe examined him and prescribed treatment for him; that he sought and obtained a cystoscopic examination from Dr. Broman, who advised him that he was afflicted with a bladder condition which should be treated; and that the obvious symptom of this condition, blood in his urine, was apparent and well known to the insured at the time he applied for insurance in March 1931. The cause of bleeding, ascertained in September 1930, had not been removed, and the report of a medical examination shows its existence in June 1931. Also, as was said by the Circuit Court of Appeals, the insured's "clear recollection of all the consultations later when he desired to use them to support his claim for compensation negatives the idea of mere forgetfulness" (R. 99).

Under the decisions relied upon by petitioner (Pet. 23–24), misrepresentation with respect to a trivial and unimportant condition may be disregarded and, as previously stated, petitioner con-

tends that the misrepresentations of the insured were of such character. The same decisions recognize, however, that misrepresentations with respect to material matters may not be disregarded, and the finding of the District Court, upon abundant evidence to warrant such finding, that the misrepresentations were material, renders these cases authorities wholly opposed to petitioner's contentions.

CONCLUSION

The decision of the Circuit Court of Appeals is correct. It presents no question of general importance, and there is involved no conflict of decisions. We respectfully submit therefore that the petition for writ of certiorari should be denied.

CHARLES FAHY,
Solicitor General.
JULIUS C. MARTIN,
Director, Bureau of War Risk Litigation.
WILBUR C. PICKETT,
KEITH L. SEEGMILLER,
W. MARVIN SMITH,
Attorneys.

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